



PREMIUM ONLY PLAN (POP) COMPLIANCE SOLUTION
CLIENT INFORMATION FORM

**Includes Plan Document, yearly restatements of the
Plan Document (as needed) and annual Nondiscrimination Testing**

**The POP Documents will be created and sent to you once payment has been received and cleared,
the POP Annual Compliance Subscription Cost is \$395.**

Company Profile

Name of Plan Sponsor (Company): _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Broker Contact: _____ Email Address: _____

Executive Officer: _____ Title: _____

Plan Administrator: _____ Title: _____

Telephone: _____ Email Address: _____

Billing Contact: _____ Email Address: _____

Type of Incorporation (please check):

☐ Partnership*

☐ Sub-chapter "C" Corporation

☐ Non-Profit Organization

☐ Sole Proprietorship*

☐ Sub-chapter "S" Corporation*

☐ Government Agency

☐ LLC (*Limited Liability Company*)*

☐ Other _____

* **Note:** Subchapter S Corporation shareholders above the 2% level **may not** participate, but they may sponsor a plan for their employees. In addition, family members and close relatives of these shareholders **may not** participate. LLC, LLP and Sole Proprietors **may not** participate, but may sponsor a plan for their employees. However, if the spouse is a bona fide employee of the firm, he or she may participate and use the benefit for the entire family.

Under Laws of (State): _____ Employer Fed Tax ID#: _____ Date of Incorporation: _____

Affiliated Employers (if any), please list. If they have a different EIN than the employer's EIN, please include that EIN

Who is your COBRA Administrator? _____

POP Plan Details

Plan Effective Date: _____ Effective Date of Amendment: _____

Start Date for this Plan Year: _____ End Date: _____

Short Plan Year?

Renewal Year Start (only if short plan year): _____ Renewal Year End (only if short plan year): _____

Participation in the Plan Begins (please check):

☐ As of date of hire

☐ From date of hire: ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other (please explain): _____

☐ First of the month following: ☐ DOH ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other (please explain): _____

Minimum Hours per Week required for benefit eligibility: _____

Coverage Ends: ☐ End of the Month ☐ Date of Termination or Loss of Coverage

Please check the benefits to be included under your Section 125 Cafeteria Plan,

You may not permit pre-tax payroll deductions unless the benefit is included in your POP:

☐ Group Medical Insurance

☐ Long-Term Disability Insurance

☐ Group Dental Insurance

☐ Short-Term Disability Insurance

☐ Group Vision Insurance

☐ Accidental Death and Dismemberment Insurance

☐ Health Savings Accounts (HSA)

☐ Critical Illness Insurance

☐ Group Term Life Cancer

☐ Hospital Indemnity Insurance

☐ Cash In Lieu of Benefits

☐ Intensive Care Insurance

☐ Special Health Event _____

☐ Other _____

Employer intends this Plan to qualify as a "Simple Cafeteria Plan" for purposes of Code Section 125(j): ☐ Yes ☐ No

A simple cafeteria plan is a type of cafeteria plan that allows small employers (those with 100 or fewer employees) to bypass annual nondiscrimination testing. Here are the key points about simple cafeteria plans:

- **Employer Size:** To qualify for a simple cafeteria plan, the employer must have 100 or fewer employees during either of the previous two years.
- **Employee Eligibility and Participation:** Generally, all employees with at least 1,000 hours of service during the preceding plan year must be allowed to participate in the simple cafeteria plan.
- **Employer Contributions:** Employers can contribute to the plan, but there are specific rules regarding the amount and type of contributions.

In summary, a simple cafeteria plan provides a streamlined way for small businesses to offer benefits without the burden of annual nondiscrimination testing.

Employer uses "Top-Paid Group" Election for 401(k) Nondiscrimination Testing purposes: ☐ Yes ☐ No

Please return this completed form to: implementation@amben.com

Printed Name: _____ Title: _____

Authorized Signature: _____ Date: _____

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